Exhibit E

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DETAILED INFORMATION ON THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF: FOCUS COUNTRIES ASSESSMENT

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Program Code	10004619
Program Title	President's Emergency Plan For AIDS Relief: Focus Countries
Department Name	Department of State
Agency/Bureau Name	Department of State
Program Type(s)	Competitive Grant Program
Assessment Year	2005
Assessment Rating	**Moderately Effective**

Assessment Section Scores

Section	Score
Program Purpose & Design	100%
Strategic Planning	100%
Program Management	90%
Program Results/Accountability	50%

Program Funding Level (in millions)

FY2007	$2,848
FY2008	$4,090
FY2009	$4,540

Ongoing Program Improvement Plans

Year Began	Improvement Plan	Status	Comments
2007	Implementing the "Staffing for Results" (SFR) model, which means having in place a fully functioning, interagency country team that jointly plans, implements, and evaluates its programs with appropriate technical leadership and	Action taken, but not completed	The goal of SFR is to institutionalize a structure, with defined roles, responsibilities, and processes that support interagency planning, implementation, and evaluation to reach Emergency Plan goals. Many countries have started their SFR analyses. In their FY 2008 COPs, countries were asked to describe their SFR processes, their successes, and

	management oversight in light of program size, number and capacity of local partners and technical experts, country working conditions, and other relevant factors.		what obstacles need to be overcome to fully implement SFR.
2007	Working to reduce the planning and reporting burden of countries that are demonstrating high performance.	Action taken, but not completed	OGAC introduced two ways to reduce the planning and reporting burden for country teams. 1) High-performing country teams were not required to complete activity narratives in their FY 08 Country Operational Plans (COPs) for those program areas that met a minimum performance criteria. 2) The mid-year progress report was reduced to collect information on the 7 country level indicators only, compared to the total 46 indicators collected in last year??s mid year report.
2007	Developing a standardized process for country teams' partner programmatic and financial performance assessments (portfolio reviews).	Action taken, but not completed	OGAC requires country teams to evaluate partner performance on a regular basis. However, in an effort to standardize the reviews, OGAC is developing a common form for country team use. In January, we will ask countries that voluntarily used the form for FY 08 COP planning to provide comments as pilot testers. We will work with all countries to finalize the form and guidance for use in FY 2009 COP planning.

Completed Program Improvement Plans

Year Began	Improvement Plan	Status	Comments
2006	The Office of the Global AIDS coordinator will establish and implement a system to capture expenditures (outlays) by country.	Completed	OGAC submitted its first report to OMB on country outlays on 2/7/07.
2006	The Office of the Global AIDS coordinator is urged to undertake an internal review of budget allocations to focus countries based on performance data and pipeline capacity.	Completed	To increase the tie between performance and budget, OGAC used both country performance data as well as pipeline data to develop the FY 2007 country budgets. OGAC collected partner financial performance assessment information in the Semi-Annual Progress Results in May 2007.

Program Performance Measures

Term	Type	
Annual	Output	**Measure:** Number of individuals provided with general HIV-related palliative care/ basic health care and support during the reporting period. Please note that beginning in 2006, both target and actual number include TB (2004 and 2005 did not include TB in either target or

actuals.)

*Explanation:*This measure is an example of a program level indicator and is standardized across the 15 focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	854,800
2005	1,662,820	1,397,555
2006	2,496,157	2,464,063
2007	3,130,341	3,901,543
2008	5,001,128	
2009	7,234,041	

Annual Output

Measure: Number of pregnant women receiving PMTCT services, including counseling and testing during the reporting period.

*Explanation:*This measure is a an example of a program level indicator and is standardized across the 15 focus countries. The actual for 2005 is from mid-year FY 2005. The target is for all of FY 2005. The data for FY05 represents initial information received from the field and will be final in the annual report to Congress in January 2006.

Year	Target	Actual
2004	Baseline	1,271,300
2005	2,372,913	1,957,932
2006	2,100,292	2,837,409
2007	3,650,949	4,011,797
2008	5,411,708	
2009	6,655,897	

Annual Efficiency

Measure: Ratio of management and staffing costs to total program costs in the 15 PEPFAR focus countries (New measure, added February 2008)

*Explanation:*The President's Emergency Plan for AIDS Relief has set an annual goal of limiting management and staffing (M&S) costs to 7% of individual country budgets. This measure evaluates the aggregate results across the 15 PEPFAR focus countries based on the Country Operational Plans for the upcoming fiscal year. M&S includes the majority of staff who provide oversight of or services to the administration of the program. The salaries for staff who work predominately in one or two technical program areas are considered to be program costs and are not included in M&S. Despite the substantial annual increase in PEPFAR funding to the 15 focus countries, the percentage that is M&S costs has decreased.

Year	Target	Actual
2005	7%	6.81%
2006	7%	6.93%
2007	7%	4.98%
2008	7%	
2009	7%	

Annual Output

Measure: Number of individuals who received counseling and testing during the reporting period (counseling includes the provision of test results to clients).

*Explanation:*This measure is an example of a program level indicator and is standardized across the 15 focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	1,791,900
2005	3,982,958	4,653,257
2006	5,590,762	6,426,120
2007	8,413,819	10,580,699
2008	12,194,714	
2009	15,947,448	

Annual Output

Measure: Number of pregnant women provided with a complete course of antiretroviral prophylaxis during the reporting period (this is a subset of women receiving PMTCT services, including counseling and testing).

*Explanation:*This measure is an example of a program level indicator and is standardized across the 15 focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	125100
2005	121439	122,717
2006	272,657	285,640
2007	351,059	294,054
2008	548,013	
2009	647,986	

Long-term Output

Measure: Estimated number of HIV infections prevented in the focus countries.

Explanation: Prevalence data released by UNAIDS in 2003 indicates that prevalence in PEPFAR focus countries ranges from a low of 0.4% in Vietnam to a high of 37.3% in Botswana. PEPFAR hopes to reduce these HIV prevalence rates, and avert 7 million infections by 2010, however calculating the number of infections averted is complicated due to the number of variables that must be factored into the equation. The Census Bureau has developed an algorithmic model to estimate the number of cases averted. This project is moving forward and to date the Census Bureau has extrapolated from 2003-2004 available pre-2005 ANC surveys and demographic data that an estimated 14,722,176 new infections would have resulted from 2005 through 2010 given pre-PEPFAR intervention levels. By the beginning of 2007 they hope to have 2005 ANC survey prevalence data for most of the focus countries, allowing for comparison between the estimated 2005 pre-intervention prevalence and the 2005 actual estimated prevalence. The difference between these two numbers will provide an estimate of the number of cases averted in 2005. Given the data requirements for this calculation, results will be available approximately 1-2 years after the reported year.

Year	Target	Actual
2004	Baseline	TBD
2007	2,800,000	Avail. FY 2009
2010	7,000,000	

Long-term Output

Measure: Number of individuals infected and affected by HIV/AIDS, including orphans and vulnerable children, receiving care and support services.

Explanation: Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	1,727,100
2005	2,600,000	2,940,677
2006	4,300,000	4,464,750
2007	5,500,000	6,637,585
2008	8,200,000	
2009	10,000,000	

Annual Outcome

Measure: Number of HIV-infected individuals (diagnosed or presumed) who received clinical prophylaxis and/ or treatment for TB during the reporting period.

Explanation: This measure is an example of a program level indicator and is standardized across the 15 focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents

a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	241,000
2005	337,242	323,144
2006	312,449	301,583
2007	426,626	367,635
2008	479,146	
2009	616,988	

Long-term Output

Measure: Number of people receiving HIV/AIDS treatment

Explanation: Baseline 2003 numbers are an aggregate of totals from different populations-based studies conducted from 1998-2002 in the 14 original focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2003	Baseline	66,911
2004	200,000	235,000
2005	470,000	401,233
2006	741,000	822,000
2007	1,200,000	1,358,375
2008	1,700,000	
2009	2,000,000	

Annual Output

Measure: Number of Orphans and Vulnerable Children (OVC) being served by an OVC program.

Explanation: This measure is an example of a program level indicator and is standardized across the 15 focus countries. Actual numbers provided during the Spring update represent a mid-year progress report (through March 31 of the fiscal year) and are not intended to be compared to the target, which represents a full year. The full-year actual numbers are updated in the Fall update and in The President's Emergency Plan for AIDS Relief Annual Report to Congress each January.

Year	Target	Actual
2004	Baseline	630,200
2005	1,393,322	1,219,978
2006	2,423,408	2,000,747
2007	3,088,766	2,736,042
2008	3,291,651	

2009	4,454,217

Questions/Answers (Detailed Assessment)

Section 1 - Program Purpose & Design

Number	Question	Answer	Score
1.1	**Is the program purpose clear?** *Explanation:* The purpose of the President's Emergency Plan for AIDS Relief, a five year, $15 billion initiative, is to turn the tide against the global AIDS pandemic. Within the Emergency Plan, the purpose of the focus country effort is to bring to scale national HIV/AIDS treatment, care and prevention programs in 15 nations of the world where the need is most urgent. *Evidence:* 1) Authorizing legislation PL 180-25 (H.R. 1298, S. 250) 2) The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global Strategy, February 2004. 3) FY 2005 Congressional Budget Justification (Overview) 4) State-USAID Strategic Plan 2004-2005, pp.4, 24-25.	YES	20%
1.2	**Does the program address a specific and existing problem, interest, or need?** *Explanation:* The 15 focus countries of the Emergency Plan represent at least 50% of HIV infections worldwide. Among these nations, HIV prevalence runs as high as 21.5% in South Africa; and in Botswana, the prevalence rate ranges from a low of 0.4% in Vietnam to a high of 37.3% in Botswana, based on 2003 UNAIDS data. All but one of the focus countries was included in the President's previously announced Mother-and-Child HIV Prevention Initiative. Key factors that contribute to the U.S. Government (USG) focusing on these nations include the severity of the magnitude of the epidemic, the strength of the USG in-country presence, and the political commitment of the host country government at the national or sub-national level. While health services in these countries, including treatment of HIV/AIDS and its associated illnesses, are limited, they are scaleable under Emergency Plan approaches, e.g., expanding access to health care services using the network model. *Evidence:* 1) The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global Strategy, February 2004. 2) AIDS Epidemic Update, December 2004, Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO). 3) "3 by 5" Progress Report December 2004, UNAIDS and WHO.	YES	20%
1.3	**Is the program designed so that it is not redundant or duplicative of any other Federal, state, local or private effort?** *Explanation:* While other international efforts share in the purpose of the Emergency Plan (to turn the tide of HIV/AIDS) and also seek to serve its beneficiaries (people living with and impacted by HIV/AIDS), the Emergency Plan is not redundant or duplicative of any other bilateral or	YES	20%

multilateral efforts that have similar goals and objectives. To ensure that this program was both successful and non-duplicative of existing USG programs, the U.S. Global AIDS Coordinator (GAC) was specifically authorized in PL 108-25 to coordinate the activities of all USG agencies responding to the international HIV/AIDS epidemic. In the focus countries during the first year of implementation, the USG in-country teams developed and implemented a unified strategy and voice in working with host governments and local nongovernmental partners. To ensure coordination with other international donors, the USG in-country team meets regularly with other bilateral and multilateral donors, the relevant host Government offices, and other implementing partners. This coordination on the ground avoids duplication of assistance efforts, eliminates program redundancies, and promotes country program synergies.

Evidence: 1) The President's Emergency Plan for AIDS Relief: U.S. Five-Year Global Strategy, February 2004. 2) Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief First Annual Report to Congress, Chapter 10, March 2005. 3) Authorizing legislation PL 180-25 (H.R. 1298, S. 250) 4) USAID Automated Directives System (ADS), Sections 201.3.6 and 201.3.7 (guidance for the preparation of strategic plans), 3/1/2004. 5) USAID ADS, Section 201.3.9.2 - Guidance on donor coordination analysis in the strategic planning phase, 1/31/2003. 6) HHS/CDC International Strategic Information and Monitoring and Evaluation Field Officer Orientation: Participant Guide and Case Studies, August 2004.

1.4	**Is the program design free of major flaws that would limit the program's effectiveness or efficiency?** *Explanation:* The authorizing language for the Emergency Plan for AIDS Relief included several earmarks specifying minimum percentages of funding to certain aspects of the program. While these earmarks are not necessary, they do not severely impede the implementation of the program. *Evidence:* 1) Authorizing legislation PL 180-25 (H.R. 1298, S. 250)	YES	20%
1.5	**Is the program design effectively targeted so that resources will address the program's purpose directly and will reach intended beneficiaries?** *Explanation:* For each of the 15 focus countries, the Emergency Plan in-country team has developed a five-year HIV/AIDS country strategy in coordination with the host government's National HIV/AIDS strategy that enables the program to adapt to the individual needs and challenges of that nation. The annual Country Operational Plans (COP) provide the Emergency Plan with distinct details on activities and funding for each focus country. By linking the Emergency Plan's five-year country strategies explicitly to the annual COP process, the Emergency Plan ensures that it effectively targets its resources to reach the intended beneficiaries, e.g., persons living with and impacted by HIV/AIDS, persons at risk of contracting HIV, and indigenous non-governmental organizations.	YES	20%

Evidence: 1) The President's Emergency Plan Country Operational Reporting System (COPRS) description. 2) Ethiopia's Five-year Country Strategy FY 2004-2008, October 2004. 3) FY 2005 Ethiopia Country Operational Plan (COP), Executive Summary.

Section 1 - Program Purpose & Design	Score	100%

Section 2 - Strategic Planning			
Number	**Question**	**Answer**	**Score**
2.1	**Does the program have a limited number of specific long-term performance measures that focus on outcomes and meaningfully reflect the purpose of the program?** *Explanation:* In the focus countries of the Emergency Plan, the long-term goals are to support treatment to 2 million HIV infected people, support the prevention of 7 million new infections, and support care for 10 million people infected and affected by HIV/AIDS (2-7-10), including orphans and vulnerable children. The 2-7-10 goals originated from data compiled in 2002 by a technical team from UNAIDS, WHO, the Futures Group, and Imperial College that estimated the global funding needs for HIV/AIDS programs and the impact that could be achieved from that funding. The treatment and care goals are to be met in 2008, and the prevention goal is to be met in 2010. Impact indicators (e.g., percent of young people age 15-24 that are HIV-infected) are being collected that will monitor the Emergency Plan's impact on turning the tide of AIDS. In addition, the Emergency Plan's 2-7-10 goals support and contribute to a set of global outcome/impact indicators which reflect all in-country partner programs, including monies from the Global Fund, UNAIDS, and other international donors. *Evidence:* The 2-7-10 goals of the Emergency Plan for AIDS Relief have been public and consistently used from the time of the President's 2003 State of the Union Address where the Plan was announced. These goals are included in every document both internal and external produced by the Office of the Global AIDS Coordinator and included in both HHS and USAID performance plans or strategies.	YES	12%
2.2	**Does the program have ambitious targets and timeframes for its long-term measures?** *Explanation:* The 2-7-10 goals are ambitious targets to be met in the five-year (seven-year for prevention goal) scope of the Emergency Plan. In the focus countries, baselines were established as follows: prevention (2002-2003); numbers of persons on treatment based on estimates from the 14 original focus countries (2003); and care (2004). Based on these overall 2-7-10 goals and baselines, each focus country developed a five-year strategy and annually submits a COP to the Office of the U.S. Global AIDS Coordinator (OGAC) for review and approval that contains the annual program level country targets that contribute to achieving the long-term program goals. Annual Emergency Plan targets towards achieving the long-term 2-7-10 goals have also been set and can be reviewed in the Global AIDS Coordinator's Bureau Performance Plan.	YES	12%

	Evidence: The baselines for prevention and treatment were established before the start of implementation of the Emergency Plan. The long-term target for persons receiving treatment represents an increase of 30 times the baseline. The prevention baseline is built off of prevalence rates. By supporting the prevention of 7 million new infections by 2010, 60% of new HIV infections in the focus countries would be prevented. While the care baseline was established during the first year of implementation, the target ambitiously calls for a 400% increase in the number of people receiving care and support services, including orphans and vulnerable children.		
2.3	**Does the program have a limited number of specific annual performance measures that can demonstrate progress toward achieving the program's long-term goals?** *Explanation:* Annual performance measures are the foundation for achieving the 2-7-10 long-term goals. The 2-7-10 goals have annual targets that build toward the long-term goals. In addition to the annual targets there are 15 programmatic indicators that are measured annually and characterized by prevention, treatment, care, and the components necessary to build sustainable capacity. These indicators include programs/services such as the Prevention of Mother-to-Child Transmission (PMTCT), antiretroviral therapy (ART), palliative care and orphans and vulnerable children (OVC), abstinence and 'be faithful' prevention services, and strategic information and policy system strengthening. Countries make projections as to the number of programs/services they will provide in the COP process just prior to the start of a new budget year. OGAC has in place an annual efficiency measure for the focus countries: dollar cost per target reached, which is a weighted cost of prevention, treatment, and care dollars. The President and the GAC have committed publicly to assisting a certain number of people in the prevention, care, and treatment of HIV/AIDS and doing so in a cost effective manner. *Evidence:* The annual goals are built into the Emergency Plan Indicators, Reporting Requirement and Guidelines. These measures are also published as part of the Emergency Plan Annual Report.	YES	12%
2.4	**Does the program have baselines and ambitious targets for its annual measures?** *Explanation:* The Emergency plan set annual targets for the 2-7-10 goals in June 2004 to be achieved in June 2005 (Year One Targets). These overall baselines and targets were reported on at the end of March 2005. Targets were set also for the end of each fiscal year 2005 through 2008. The program level output indicators that are also reported annually have a baseline established in 2004 since this is the first year that data was collected in this level of detail on the 15 core indicators. OGAC is able to successfully measure progress towards the 2-7-10 goals of the Emergency Plan biannually based on reports submitted by the country teams. The targets are reviewed to assure they reflect a measurable outcome as well as consistent movement towards achieving the long-term goals of the Emergency Plan.	YES	12%

Evidence: Emergency Plan 2-7-10 prevention, treatment and care goals were set annually beginning in June 2004 with Year One targets and results collected at the end of March 2005. Targets were also set for the end of the fiscal years 2005 through 2008, as referenced in the programs' planning documents. The program level indicators set baselines for prevention, care, and treatment in 2004, and first year targets were set for 2005. The first results to measure the accomplishment will be in September 2005.

2.5	**Do all partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) commit to and work toward the annual and/or long-term goals of the program?**	YES	12%

Explanation: In-country coordination and planning between partners at all levels is a founding implementation and management principle of the Emergency Plan. All focus countries have a five-year strategic plan that was developed in consultation with relevant USG entities, host-country governments, non-governmental organizations (NGOs) including faith based organizations, the corporate sector, multilateral institutions, and other in-country stakeholders. The Emergency Plan recognizes that the host countries must own the fight against HIV/AIDS; thus, the Emergency Plan's approach to support host countries' national strategies, including building local capacity for sustainable HIV/AIDS programs.

Evidence: Evidence for this answer can be found in the following documents: 1) Uganda Five-Year Strategic Plan FY2004 - 2008. 2) The Ethiopia Five-Year Strategy and FY05 COP 3) The President's Emergency Plan for AIDS Relief. U.S. Five-Year Global HIV/AIDS Strategy, Chapter 9, February 2004. 4) USAID ADS 350 - Grants to Foreign Governments, 7/23/2003. 5) USAID ADS 303.5.5b and 303.5.5c, 7/23/2002. 6) USAID Task Order Proposal Request for Preventing the Medical Transmission of HIV: Reducing Unsafe and Unnecessary Injections in Selected Countries of Africa and the Caribbean. 7) USAID Population, Health and Nutrition Technical Assistance Support Contract, 9/30/2003.

2.6	**Are independent evaluations of sufficient scope and quality conducted on a regular basis or as needed to support program improvements and evaluate effectiveness and relevance to the problem, interest, or need?**	YES	12%

Explanation: The Institute of Medicine (IOM) and the General Accounting Office (GAO) evaluations have either been completed, or are underway, that cover the scope of the Emergency Plan in the focus countries including treatment, care, and prevention programs. IG reports from USAID and the State Department have, or are also, evaluating management and value questions. Finally, the Office of the U.S. Global AIDS Coordinator (OGAC) has retained an independent contractor to evaluate compliance with USG "ABC" (Abstinence, Be Faithful and correct and consistent Condom use) policy, movement towards use of indigenous partners, performance and results achievement against targets, and reasonableness of cost.

	Evidence: 1) List of Ongoing and Recently Completed Audits and Evaluations of the President's Emergency Plan. 2) GAO Audit, Titled: Global HIV/AIDS Epidemic: Selection of Antiretroviral Medications Provided under U.S. Emergency Plan is Limited, January 2005. 3) GAO-04-784: U.S. AIDS Coordinator Addressing Some Key Challenges to Expanding Treatment, but Others Remain.2004. 4) Institute of Medicine. Scaling Up Treatment for the Global AIDS Pandemic: Challenges and Opportunities. July 2004. "		
2.7	**Are Budget requests explicitly tied to accomplishment of the annual and long-term performance goals, and are the resource needs presented in a complete and transparent manner in the program's budget?** *Explanation:* The Office of the Global AIDS Coordinator develops budget requests and analysis of policy impacts taking into account accomplishment of long-term and annual goals both through internal and external presentations. The internal interagency Emergency Plan strategic planning process requires that country budget requests be tied explicitly to the strategic performance planning process. These internal discussions of budget and performance are the basis of external budget requests. *Evidence:* Internal budget analysis was provided demonstrating funding scenarios and the impact they would have on the accomplishment of long-term and annual goals. OGAC has developed an FY 2007 template tying budget request to performance. The Country Operational Plans also require that funding requested is tied to activities that will accomplish the program's goals.	YES	12%
2.8	**Has the program taken meaningful steps to correct its strategic planning deficiencies?** *Explanation:* There are no strategic planning deficiencies identified in this section that require programmatic corrections. *Evidence:* Evidence is unnecessary.	YES	12%
	Section 2 - Strategic Planning	Score	100%

Section 3 - Program Management			
Number	**Question**	**Answer**	**Score**
3.1	**Does the agency regularly collect timely and credible performance information, including information from key program partners, and use it to manage the program and improve performance?** *Explanation:* The program collects performance data from grantees and the field and uses the data to manage and improve program performance. The program has established program reporting, monitoring and surveillance systems. The program collects data through country plans and reports and uses the data to make program and funding decisions by country. Country Operational Plans (COPS) include specific details on	YES	10%

proposed accomplishments and deliverables. The plans are used to manage the program and improve performance. For grants and contracts, program partners commit to and report on performance goals that are approved in the annual COP. Additional information on program activities and performance is collected through program audits, field visits, outcome indicators, progress indicators, and obligation reports.

Evidence: Evidence includes the annual report to Congress, Country Operational Plans and annual reports, grant guidance materials, and sample country reviews. Examples of cost effectiveness studies that the program has used to manage and improve performance include: cost effectiveness of tuberculin skin testing for HIV infected persons in Uganda, effect of co-trimoxazole prophylaxis in HIV infection and the cost effectiveness of home-based chlorination and safe water storage among HIV-affected families.

3.2	**Are Federal managers and program partners (including grantees, sub-grantees, contractors, cost-sharing partners, and other government partners) held accountable for cost, schedule and performance results?** *Explanation:* SES and senior program managers for the program have performance-based work plans. As noted in Section I, program design is strong in the reliance on existing structures and implementing agencies and appropriations for the focus countries are provided through multiple accounts. However, this arrangement requires additional efforts in oversight of performance and financial data that will require continued effort. The program is working to establish clearly defined and quantifiable performance standards for the majority of program managers within the State Department, HHS and USAID. The program establishes performance standards for partners, including grantees and country level teams. Project officers receive annual reports documenting progress that could be the basis for not extending additional funding due to poor performance. Program staff review country spending trends and, where indicated, request additional justification or reallocate funds. Past performance is a criterion in the awards from both implementing agencies. *Evidence:* Evidence includes copies of workplans for SES and senior managers, technical reviews, grant program announcements, administration manuals and Country Operational plans. Country Operational plans provide detailed information on proposed activities and deliverables. For the next General Service (GS)/Foreign Service(FS) rating period, HHS and USAID will update these work plans so that they are performance based and tie directly to relevant staff roles and responsibilities.	YES	10%
3.3	**Are funds (Federal and partners') obligated in a timely manner and spent for the intended purpose?** *Explanation:* The program obligates funds in a timely manner and for the intended purpose. Funds are largely obligated according to planned schedules with a limited amount of program funds remaining at the end of the year. The funding plans at the headquarters level emphasize rapid	YES	10%

distribution of funds to the field. In the field, country programs may obligate funds more slowly depending on the maturity and position of the country program. The program monitors any large sums of unobligated balances in the field as a possible indication that there are problems meeting proposed goals and objectives. The program presents obligations as a percentage of what is available and outlays as a percentage of obligations by appropriation. As is described further below, the program is also actively working to improve reporting of final expenditures by tracking outlays by country and comparing those outlays against the intended use.

Evidence: Evidence includes the Annual Report to Congress, headquarter reports and obligations and outlay data from the program. The Emergency Plan received the first appropriation in January 2004 and released the first $350 million for the focus countries in February 2004 and an additional $515 million in June 2004. The program's obligation data is collated quarterly by country for field obligations and by area for central programs.

3.4	**Does the program have procedures (e.g. competitive sourcing/cost comparisons, IT improvements, appropriate incentives) to measure and achieve efficiencies and cost effectiveness in program execution?**	YES	10%

Explanation: The program has adopted an efficiency measure of the cost per target reached that can be useful to monitoring program performance at the country and aggregate level. The program monitors overhead costs in the Coordinator's office and implementing agencies and has taken steps to avoid rapid scale up of Federal FTE positions in the implementing agencies. The program improves efficiency in the field, in part, through the "Three Ones" process described in the response to question 3.5. The implementing agencies have some procedures in place, including competitive sourcing studies and mission reviews, to improve overall efficiency. The program is working on systems for supply chain management and establishing an IT contract. Although the IT evaluation has been slow in development, the Coordinator's office has committed to ensuring that the recommendations of the evaluation maximize existing USG IT models and capabilities.

Evidence: The program adopted an efficiency measure for the focus countries: dollar cost per target reached, which is a weighted cost of prevention, treatment, and care dollars. An example of evidence to demonstrate efficiency is the establishment of a web based Country Operation plan database system. CDC has taken a number of steps to improve efficiency including competitive sourcing studies and consolidations of IT, budget execution, travel processing and training. USAID is using Mission Management Assessments to review activities by region. This effort led to savings through the consolidation of activities in the Caribbean region.

3.5	**Does the program collaborate and coordinate effectively with related programs?**	YES	10%

Explanation: The program emphasizes coordination and collaboration between the Coordinator and the implementing agencies that make up the

program, between the implementing agencies, between the program and other international actors such as the Global Fund and World Bank, and between the USG in the field and the local governments and non-governmental entities. Ensuring stability and sustainability of local activities funded by the program and its bilateral and multilateral partners will require continued success in collaborative planning. Some improvements could be made in collaboration with the State Department specifically in the areas of human resources and legislative affairs.

Evidence: One prominent example of collaboration between the program and external partners is the program has agreed to a set of principles with UNAIDS, the World Bank and the U.K. Department for International Development known as the "Three Ones." These principles include the mutual agreement to one HIV/AIDS action framework to help coordinate the work of all partners in a country, one national AIDS coordinating authority in the country and one agreed upon country-level monitoring and evaluation system. According to data from the program, in the first eight months of implementation in the focus countries, 80% of the 1,200 partners working in the field were indigenous organizations.

3.6	**Does the program use strong financial management practices?**	NO	0%

Explanation: The program has mechanisms for financial accountability and control, but does not yet meet the standards of this question for strong financial management practices. As is described further below, HHS/CDC has implemented a new financial management system that is designed to eliminate previously identified weaknesses in the legacy system. USAID is also working to adopt a new financial management system in all overseas missions and headquarters. When all systems are in place and evidence is available that the new systems have strengthened financial management for the agencies and are resolving previously identified weaknesses the response to this question will be yes.

Evidence: Evidence includes prior year performance and accountability reports, reports on material weaknesses, financial management reports and financial management procedures.

3.7	**Has the program taken meaningful steps to address its management deficiencies?**	YES	10%

Explanation: The program is taking steps to address weaknesses identified in this section. CDC recently adopted a new financial management system and is also establishing a financial management guide for countries. USAID is in the process of implementing a new accounting system at headquarters and in all of its missions. The program is developing a plan for collecting and reporting outlay data by country. The program is also extending performance results information into the evaluations of additional Federal General Service and Foreign Service managers.

Evidence: Evidence includes internal planning documents and implementation plans for the financial management systems. HHS's financial management guide will address budget management, travel approvals and vouchers, grants management, ICASS and securing of

assets. GAO has noted the challenges facing the Coordinator expanding treatment in the focus countries and documented early successes of Emergency Plan implementation (see GAO-04-784).

3.CO1	**Are grants awarded based on a clear competitive process that includes a qualified assessment of merit?** *Explanation:* Grants are largely awarded according to a competitive process based on merit. The program uses independent review and ranking of applicants to make award decisions. *Evidence:* Both HHS and USAID announce competition for global AIDS funds by placing program announcements in the Federal Register: (www.gpoaccess.gov/fr/index.html) and the Catalogue of Federal Domestic Programs: (www.cfda.gov/public/faprs.html). Awards are made through an objective review process or special emphasis panel. Continuation awards go through a technical review process. Overall, more than 90% of extramural funds for the program are awarded competitively.	YES	10%
3.CO2	**Does the program have oversight practices that provide sufficient knowledge of grantee activities?** *Explanation:* The program in general has an understanding of how its funds are utilized by grantees. The program tracks progress through required reports, frequent site visits and audits. The program described a process whereby program managers track expenditures regularly as part of their responsibilities and conduct field visits to ensure that funding is being used for its intended purposes. Field audits also focus on whether funding was used for its intended purposes. OGAC reviews aggregate expenditure information quarterly. *Evidence:* Grantees submit Interim Financial Status Reports within 90 days of the close of the calendar year. The program has field staff that monitor country-level agreements. In the case of HHS, these staff act as project officers for the local grants. USAID uses cognizant technical officers (CTO) and strategic objective team leaders. Evidence includes sample site visit reports, guidelines for audits and for technical officers and the reporting structure.	YES	10%
3.CO3	**Does the program collect grantee performance data on an annual basis and make it available to the public in a transparent and meaningful manner?**	YES	10%

Section 4 - Program Results/Accountability			
Number	**Question**	**Answer**	**Score**
4.1	**Has the program demonstrated adequate progress in achieving its long-term performance goals?** *Explanation:* Within the confines of what is feasible in the international setting, the program will make available to the public country level data on services provided toward the achievement of the program's performance measures and country level data reflecting changes in the HIV/AIDS burden. It does not provide grantee specific performance data to the public for the over 1,200 grantees and subgrantees. *Explanation:* The Emergency Plan has demonstrated measurable progress towards two of the three long-term goals. Both the treatment and care 2004 long-term goals were exceeded during the reporting period ending March 2005. The end of FY 2005 goal for care was exceeded but the goal for treatment was missed by approximately 70,000 people. A variety of factors contributed to this result, including the fact that, due to quality issues with host government data, country teams could not submit USG *Evidence:* Evidence includes the annual report to Congress and the web sites of the Coordinator and implementing agencies.	SMALL EXTENT	8%

Section 3 - Program Management	Score	90%

	upstream results in five of the 15 focus countries. The program is working to resolve these issues with host governments so that the full extent of U.S.G. support for treatment can be reported. The prevention goal will be evaluated in tri-annual snapshots starting in 2006. Until then, only annual targets of persons reached with prevention messages are available. It is important to note that the actual for 2005 is from mid-year 2005, whereas the target is for all of 2005. Based on progress as of mid-year 2005, the program is on track to exceeding its goals for the full year of 2005. *Evidence:* The Emergency Plan has exceeded the year one target for total number of people receiving antiretroviral therapy by almost 18%. The target was 200,000 persons on treatment and the result of one full year of implementation was a total of 235,000. The target for people reached with care and support services was 1,200,000 and the result was 2,009,259. The FY 2005 target for treatment was 470,000 people on treatment and preliminary data indicates that 401,233 people are on treatment. The care goal was 2,600,000 people receiving care services and 2,940,677 were served.		
4.2	**Does the program (including program partners) achieve its annual performance goals?** *Explanation:* Baselines were established in FY 2004 for each of the annual indicators of the Emergency Plan. Annual targets for FY 2005 were also set. Preliminary results data for the end of FY 2005 indicates that most countries are achieving or exceeding their care, treatment, and PMTCT targets. *Evidence:* FY 2005 Annual Report data provided internally to OMB and will be published in the Annual Report to Congress in January 2006.	LARGE EXTENT	17%
4.3	**Does the program demonstrate improved efficiencies or cost effectiveness in achieving program goals each year?** *Explanation:* The Emergency Plan's efficiency measure begins with an FY2004 baseline and has its first target in FY2006. As such, a small extent is given because not enough time has passed for comparison. The baseline and targets reflect a reasonable starting point of efficiency in the field and ambitious reduction in unit costs for meeting program targets. As is noted in the evidence, the program has controlled administrative expenses and the implementing agencies have achieved other savings in execution. *Evidence:* The efficiency measure is dollars per target reached. The program's baseline in FY 2004 per person reached is $232 for prevention, $195 for care and $1,634 for treatment, reflecting a reasonable baseline of costs per unit and evidence to support the small extent rating. The program anticipates reductions beginning in FY 2006 through FY 2008. The implementing agencies have largely maintained their headquarter costs at FY 2004 levels despite the dramatic increase of program dollars under the Emergency Plan. An agency example of cost savings not specific to the program include CDC consolidation of all 13 IT infrastructure services, with reduced operating costs of 21% and redeployment of 18%	SMALL EXTENT	8%

	of staff to mission direct duties into the Information Technology Services Office in December 2003. As the program matures and data on efficiency gains for this measure and at the Federal execution level are collected, the response to this question is anticipated to change.		
4.4	**Does the performance of this program compare favorably to other programs, including government, private, etc., with similar purpose and goals?** *Explanation:* A large extent is given because studies are not available comparing the effectiveness or efficiency of this program with similar efforts, such as the Global Fund or HIV/AIDS bilateral efforts of partner countries, but there is evidence that the program performs favorably in moving quickly and meeting the first year of targets. The program is the largest international health initiative initiated by one nation to address a single disease and has shown early progress in meeting objectives. The program moved very quickly to set up requisite mechanisms and policies with an emphasis on accountability and results from efforts in the field and disbursed initial appropriations to the field and other partners in a short-period of time. *Evidence:* In FY 2004, the program committed $865 million for national scale-up of prevention, treatment and care programs in the 15 focus countries, six months after receipt of the appropriation. The program has exceeded its first year goals for number of individuals receiving antiretroviral treatment. In the first year, the program also supported 3,800 programs for prevention, 300 sites for treatment, and more than 8,000 sites for care.	LARGE EXTENT	17%
4.5	**Do independent evaluations of sufficient scope and quality indicate that the program is effective and achieving results?** *Explanation:* This question's score has been re-weighted to zero due to the newness of the Emergency Plan. With under two full years of implementation, several evaluations are currently in process or planned but not yet completed. Several of the independent evaluations conducted on the Emergency Plan's focus-country initiative were completed early in the program's implementation and did not (or did not seek to) provide information on the program's impact or effectiveness. These reports did provide important information regarding the obstacles facing the Coordinator's Office in implementing the program, and subsequently have helped OGAC to strengthen their strategic and program planning efforts. The results of a USAID Inspector General Audit released in March 2005 were judged to be not of sufficient scope, as the audit looked only at USAID/Emergency Plan activities in Ethiopia. The only other completed evaluation of the program was released by the GAO in January 2005 and concluded that the Emergency Plan provided a smaller selection of recommended first-line ARVs than other major HIV/AIDS treatment initiatives in developing countries. The program expressed concern over the GAO's lack of attention to issues of quality assurance in relation to the availability of ARVs. The program acknowledges that safety and efficacy - and not just cost-effectiveness of prices - impact the range of products available for purchase under the Emergency Plan.	NO	0%

Evidence: "1) GAO-05-133: GAO Audit, Titled: Global HIV/AIDS Epidemic: Selection of Antiretroviral Medications Provided under U.S. Emergency Plan is Limited, January 2005. 2) GAO-04-784: U.S. AIDS Coordinator Addressing Some Key Challenge to Expanding Treatment, but Others Remain.2004. 3) Institute of Medicine. Scaling Up Treatment for the Global AIDS Pandemic: Challenges and Opportunities. July 2004. 4) USAID Office of the Inspector General. Audit of USAID/Ethiopia's Implementation of The President's Emergency Plan for AIDS Relief, March 30, 2005.

Section 4 - Program Results/Accountability	Score	50%

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